Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MEMORIAL HERMANN HOSPITAL SYSTEM
3200 SW FREEWAY STE 2200
HOUSTON TX 77027

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-09-3335-01

MFDR Received Date

NOVEMBER 25, 2008

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The amount paid by the carrier for the outpatient surgery falls below the hospital's expected reimbursement under the Acute Care Inpatient Hospital Fee Guideline (ACIHFG) found in Commission Rule 134.401(a)(4). Because this admission was for out-patient surgery, there is no particular fee schedule and the hospital should be reimbursed at a fair and reasonable rate. The carrier instead paid of fraction of the Operating Room expenses and denied all other charges using an unknown method of calculating benefits. The payment by the carrier amounts to less than 15% reimbursement on this surgery which is inherently unfair and unreasonable. On its face, the amount paid by the carrier for this surgery is wholly unreasonable under any discernable standard. The carrier has not and cannot demonstrate that a reduction of total charges by more than 85% constitutes a fair and reasonable rate of reimbursement, especially for treatment of the injuries suffered by this patient. Further, there is not reasonable explanation for the deductions taken by the carrier. The Commission specifically carved out from the fee guidelines out-patient surgery and commanded that it be reimbursed at a fair and reasonable rate... Requestor submits that a fair and reasonable rate for surgeries performed on this employee are the usual and customary charges incurred."

Amount in Dispute: $22,887.54

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The nationally recognized published studies in the context of this dispute is Medicare, if for no other reason that the change to the Labor Code brought about by House Bill 2600. However, the requestor cites no such nationally recognized study. Nowhere does the request explain in some detail why $27,028.00 is an appropriate charge for the surgical procedure rendered… Since the requestor's fee amount appears to be based upon data other than Medicare, as affirmed by HB 2600, the requestor's proposed fee does not satisfy Rule 134.1(d)(3). The requestor's proposed fee exceeds known fair and reasonable amounts."

Response Submitted by: Texas Mutual Insurance Co., 6210 E. Hwy 290, Austin, TX 78723

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
December 12, 2007	Outpatient Surgery	$22,887.54	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. This request for medical fee dispute resolution was received by the Division on November 25, 2008.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W10 – No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology.
   - 426 – Reimbursed to fair and reasonable
   - 713, 894 – Fair and reasonable reimbursement for the entire bill is made on the 'O/R Service' line item.
   - 719 – Reimbursed at carrier's fair & reasonable costs data unavailable for facility. Additional payment be considered if data is submitted.

Findings

1. This dispute relates to services with reimbursement subject to the provisions of Texas Administrative Code §134.1, effective May 2, 2006, 31 *Texas Register* 3561, which requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
2. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
3. 28 Texas Administrative Code §133.307(c)(2)(F)(iii), effective May 25, 2008, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, requires that the request shall include "a position statement of the disputed issue(s) that shall include"… "how the Labor Code, Division rules, and fee guidelines impact the disputed fee issues." Review of the submitted documentation finds that the requestor has not discussed how the Labor Code, Division rules and fee guidelines impact the disputed fee issues. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(F)(iii).
4. 28 Texas Administrative Code §133.307(c)(2)(G), effective May 25, 2008, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:
   - The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for the disputed services.
   - Documentation of the amount of reimbursement received for these same or similar services was not presented for review.
   - The Division has previously found that "hospital charges are not a valid indicator of a hospital's costs of providing services nor of what is being paid by other payors," as stated in the adoption preamble to the Division's former *Acute Care Inpatient Hospital Fee Guideline*, 22 *Texas Register* 6276. It further states that "Alternative methods of reimbursement were considered… and rejected because they use hospital charges as their basis and allow the hospitals to affect their reimbursement by inflating their charges…" 22 *Texas Register* 6268-6269. Therefore, the use of a hospital's "usual and customary" charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.

- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

		September 19, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.